IDAHO DEPARTMENT OF
HEALTH & WELFARE

C.L. "BUTCH" OTTER – Governor
RICHARD M. ARMSTRONG – Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief
BUREAU OF FACILITY STANDARDS
3232 Elder Street
P.O. Box 83720
Boise, ID 83720-0036
PHONE 208-334-6626
FAX 208-364-1888

March 16, 2007

Steven Horton
Family Hospice
2950 East Magic View, Suite 192
Meridian, ID 83642

Dear Mr. Horton:

This is to advise you of the findings of the Medicare survey, which was concluded at your facility, Family Hospice, on March 15, 2007.

Enclosed is your copy of a Statement of Deficiencies/Plan of Correction, form CMS-2567, which states that no deficiencies were noted at the time of the survey.

Thank you for the courtesies extended to us during our visit. If we can be of any help to you, please call our office at (208)334-6626.

Sincerely,

PENNY SALOW
Health Facility Surveyor
Non-Long Term Care

SYLVIA CRESWELL
Supervisor
Non-Long Term Care

PS/mlw

Enclosure

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	FHINIT	A. BUILDING _____ B. WING _____	03/15/2007

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
FAMILY HOSPICE	2950 E. MAGIC VIEW. SUITE 192 MERIDIAN, ID 83642

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
L 000	INITIAL COMMENTS No deficiencies were cited during the initial Medicare certification survey of your hospice agency. Family Hospice is in compliance with the requirements of 42 CFR Part 418, Conditions of Participation for Hospices. The surveyors conducting the initial Medicare certification survey were: Penny Salow, R.N., H.F.S., Team Leader Patrick Hendrickson, R.N., H.F.S.	L 000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.